UNREPORTED

IN THE COURT OF SPECIAL APPEALS

OF MARYLAND

No. 0969

September Term, 2015

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MAXINE KONTOSIS

v.

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

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Berger,
Reed,
Shaw Geter,

JJ.

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Opinion by Berger, J.

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Filed: October 28, 2016

*This is an unreported opinion, and it may not be cited in any paper, brief, motion, or other document filed in this Court or any other Maryland Court as either precedent within the rule of *stare decisis* or as persuasive authority. Md. Rule 1-104.

This appeal involves a dispute regarding an offset provision applied by appellee, the Hartford Life and Accident Insurance Company ("Hartford"), to a disability insurance policy held by appellant, Maxine Kontosis ("Kontosis"). Kontosis filed a complaint with the Maryland Insurance Administration ("MIA")[1] alleging that the offset constituted an unfair claims settlement practice. After an investigation and a hearing before an Administrative Law Judge ("ALJ"), the deputy commissioner of the MIA determined that Hartford had not engaged in an unfair claims settlement practice.

On July 28, 2014, Kontosis filed a petition for judicial review in the Circuit Court for Prince George's County. On June 5, 2015, the circuit court affirmed the MIA's final order in Hartford's favor. This timely appeal followed. On appeal, Kontosis presents two issues for our review,[2] which we consolidate and rephrase as follows:

> Whether there was substantial evidence to support the MIA's determination that Hartford had not engaged in unfair claim settlement practices.

[1] Notably, the MIA filed a notice of intent not to participate in the judicial review proceedings before the circuit court. Likewise, the MIA did not file a brief or present argument before us in this appeal.

[2] The issues, as presented by Kontosis, are:

> A. Whether a Licensee's improper use of a disability policy's offset provisions constituted an unfair claim settlement practice in violation of the Maryland Insurance Article?
>
> B. Whether an Administrative Law Judge improperly concluded that section 15-501 of Insurance Article was inapplicable when he erroneous [sic] found that disability insurance policies are not health insurance policies as defined by the Article?

For the reasons set forth below, we shall affirm the judgment of the Circuit Court for Prince George's County.

## FACTUAL AND PROCEDURAL BACKGROUND

Kontosis is a retired physical education teacher who was employed with the Prince George's County Public School System. During her employment, Hartford underwrote three disability insurance policies for Kontosis: Policy No. GLT-675844 (the "group policy"), Policy No. AGP-5630 (the "association policy"), and Policy No. AGP-5295 (the "second association policy").[3] Although all three policies were underwritten by Hartford, Hartford operated each policy independently of the others in accordance with the respective terms of each. The group policy provided for a maximum benefit of sixty percent of the policyholder's monthly pre-disability earnings up to a maximum of $5,000.00 per month, and a minimum benefit of the greater of $100 or 10% of the policyholder's previous gross monthly salary, which was calculated to be $433.84 per month. The association policy, on the other hand, provided a maximum benefit of sixty-six and two-thirds percent of the policyholder's monthly salary up to a maximum amount of $4,000.00 per month, and a minimum benefit of $100 per month.

[3] The second association policy limited benefits to two years beginning in 2010 and ending in 2012. Kontosis applied for and received benefits pursuant to this third policy. Accordingly, Hartford's payments of benefit pursuant to the second association policy is not subject to dispute in this appeal.

Both the group and association policy permit Hartford to offset the amount of a policyholder's monthly benefit payments to the extent that the policyholder receives "Other Income Benefits." Other income benefits, under the association policy:

> means the amount of any benefit for loss of income, provided to the Insured Person or to the Insured Person's family, as a result of the period of Disability for which the Insured Person is claiming benefits under this plan. This includes any such benefits for which the Insured Person or the Insured Person's family is eligible or that are paid to the Insured Person, to a third party on the Insured Person's behalf, pursuant to any:
>
> a) temporary or permanent disability benefit under a Workers' Compensation Law, occupation disease law, or similar law;
>
> b) governmental law or program that provides disability or unemployment benefits as a result of the Insured Person's job with the employer;
>
> c) plan or arrangement of coverage, whether insured or not, as a result of employment by or association with the Employer or as a result of membership in or association with any group, association, union or other organization;
>
> . . .
>
> f) disability benefits under the United States Social Security Act . . .or similar plan or act that the Insured Person or, the Insured Person's spouse and children are entitled to receive because of the Insured Person's disability.
>
> **Other Income Benefits** also means any such payments that are made to the Insured Person, his or her family or to a third party on his or her behalf, pursuant to any:
>
> . . .
>
> d) retirement benefits under the United States Social Security Act . . . or similar plan or act that the Covered Person received

> because of his or her retirement, unless the Insured Person was receiving them prior to becoming Disabled.

"Other Income Benefits" is similarly defined under the group policy. The parties agree that under both the group and association policy, "Other Income Benefits" includes income received from Social Security Disability Insurance ("SSDI"), benefits paid under other disability insurance policies, and employer-paid retirement benefits. Moreover, both policies require that the policyholder apply for SSDI benefits upon Hartford's request. If the policyholder fails to apply for SSDI benefits, the policyholder may be denied benefits under the respective insurance policies.

In 2010, Kontosis sustained an injury to her knee. Thereafter, on May 27, 2010, Kontosis stopped working. In early 2011, Kontosis was advised by her physician that she should retire because her condition negatively impacted her ability to perform her job duties. Accordingly, Kontosis retired, and on February 24, 2011, she applied for long-term disability benefits under the association policy.[4] Later, on March 15, 2011, Kontosis also applied for long-term disability benefits under the group policy. Hartford approved both requests for benefits, and her benefits were to begin under both policies on June 21, 2011.

[4] Kontosis disputes that there is a causal relationship between her disability and her retirement. Rather, Kontosis contends that "her retirement from the Prince George's County School Board was not based upon her disability but rather her qualifying years of service." The reason Kontosis chose to retire in 2011, however, is immaterial for our analysis in this appeal.

Before the application of the "other benefit" offset, Hartford calculated Kontosis's benefit under the group policy to be $4,338.35 per month, and $723.58 per month under the association policy. At the direction of Hartford, and pursuant to her obligation under the group policy, Kontosis applied for SSDI benefits. Kontosis was approved to receive $2,293.20 per month in SSDI benefits, and that amount was later increased to $2,302.20 per month. Additionally, Kontosis received a monthly pension of $3,892.00, which was also offset against her disability benefits. Accordingly, because Kontosis's other income exceeded her calculated benefit, Hartford reduced Kontosis monthly payment under the group policy to the minimum payment of $433.84 per month under the group policy. Due to an error by a claim's analyst as to Kontosis's minimum monthly benefit under the association policy, Kontosis received a monthly benefit under that policy in the amount of $723.58 per month. When Hartford discovered the error with respect to the association policy, Kontosis's benefit under that policy was reduced to $100 per month. Hartford did not seek compensation for the overpayment under the association policy.

On October 24, 2011, Hartford reduced the amount calculated as other income under the group policy by half of the amount of SSDI benefits Kontosis received, and applied that half as other income under the association policy. Moreover, Hartford determined that it was improper to assess Kontosis's monthly pension as other income under the group policy. Accordingly, Hartford paid Kontosis $11,931.81 which represented the amount of the underpayment, and increased her benefit under the group policy accordingly. The half

of Kontosis's SSDI benefits that were calculated as other income under the association policy, however, had no effect on her benefit under that policy because Kontosis was already receiving the minimum benefit under that policy. Also on February 14, 2012, an additional underpayment benefit was issued to Kontosis in the amount of $4,888.78.

Later, on February 5, 2013, Hartford terminated payments under the group policy because Kontosis failed to receive an updated medical evaluation verifying her continued disability as required under that policy. Because Kontosis was no longer receiving payments under the group policy, Hartford increased Kontosis's payments under the association policy from $100.00 to $1,747.82 for February of 2013 and $2,518.62 monthly thereafter. Later, Hartford received updated medical documentation evincing that Kontosis was still disabled. Following an administrative appeal, Hartford reinstated benefits under the group policy and issued a retroactive payment in the amount of $30,318.13. Further, because Kontosis was again receiving payments under the group policy, the offset to the association policy was reinstated and her payment under that policy were again reduced to $100 per month.

Hartford determined, however, that because Kontosis was entitled to--and in fact subsequently received--benefits under the group policy, Hartford was entitled to the offset that would have been applied under the association policy had Kontosis received benefits under the group policy. Accordingly, Hartford determined that it had overpaid Kontosis by $18,578.16 under the association policy between the time benefits were not paid under

the group policy and the time benefits were reinstated. When Hartford sought remittance of the overpayment under the association policy, Kontosis refused. Accordingly, on October 1, 2013, Hartford began withholding $100.00 per month under the association policy, leaving Kontosis receiving no payments under that policy.

Thereafter, Kontosis filed a *pro se* complaint with the MIA challenging the offsets Hartford applied to her policy and Hartford's request that Kontosis sign a form authorizing Hartford to obtain and disclose information. The MIA conducted an investigation and found that Hartford had not engaged in unfair claims settlement practices. Thereafter, on April 24, 2014, a hearing was held before an ALJ where the judge concurred that Hartford had not engaged in unfair claim settlement practices. The ALJ's decision was largely adopted by the deputy commissioner of the MIA. Kontosis then filed a petition for judicial review in the Circuit Court for Prince George's County, where the agency's decision was affirmed. This timely appeal followed. Additional facts will be discussed as necessitated by the issues presented.

## DISCUSSION

### I. Standard of Review

"'On appellate review of the decision of an administrative agency, this Court reviews the agency's decision, not the circuit court's decision.'" *Long Green Valley Ass'n v. Prigel Family Creamery*, 206 Md. App. 264, 273 (2012) (quoting *Halici v. City of Gaithersburg*, 180 Md. App. 238, 248 (2008)); *Ware v. People's Counsel for Balt. Cnty.*, 223 Md. App.

669, 680 (2015) ("In an appeal from a judgment entered on judicial review of a final agency decision, we look 'through' the decision of the circuit court to review the agency decision itself."). Moreover,

> "Our review of the agency's factual findings entails only an appraisal and evaluation of the agency's fact finding and not an independent decision on the evidence. This examination seeks to find the substantiality of the evidence. That is to say, a reviewing court . . . shall apply the substantial evidence test to the final decisions of an administrative agency . . . In this context, substantial evidence, as the test for reviewing factual findings of administrative agencies, has been defined as such relevant evidence as a reasonable mind might accept as adequate to support a conclusion."

*Tomlinson v. BKL York LLC*, 219 Md. App. 606, 614 (2014) (alterations omitted) (quoting *Catonsville Nursing Home, Inc. v. Loveman*, 349 Md. 560, 568-69 (1998)).

While we largely defer to the factual findings of an administrative agency, "reviewing courts are under no constraint to affirm an agency decision premised solely upon an erroneous conclusion of law." *Ins. Comm'r for the State v. Engelman*, 345 Md. 402, 411 (1997). Indeed, "with respect to an agency's conclusions of law, we have often stated that a court reviews *de novo* for correctness." *Schwartz v. Md. Dept. of Natural Res.*, 385 Md. 534, 554 (2005). Although we review an agency's legal conclusions *de novo*, "an administrative agency's interpretation and application of the statute which the agency administers should ordinarily be given considerable weight by reviewing courts." *Md. Div. of Labor & Indus. v. Triangle Gen. Contractors, Inc.*, 366 Md. 407, 416 (2001) (quoting *Bd. of Physician Quality Assurance v. Banks*, 354 Md. 59, 69 (1999)).

Accordingly, in the present appeal we will defer to the factual findings of the ALJ so long as they are supported by substantial evidence. We will, however, review any legal determinations under the *de novo* standard.

## II. The MIA Did Not Err In Finding That Hartford Did Not Engage in Unfair Claims Settlement Practices.

In her appeal, Kontosis challenges the MIA's determination the Hartford had not engaged in an unfair claims settlement practice. In support of her argument, Kontosis contends that Hartford engaged in unfair claims settlement practices to classify benefits received from the group policy and SSDI as other income under the association policy. Additionally, Kontosis alleges that it was an unfair claims settlement practice to seek reimbursement for the overpayment Hartford made as a result of not applying offsets under the association policy for the period that Hartford was not paying benefits under the group policy. Finally, Kontosis avers that the MIA erred when it determined that Md. Code (1995, 2011 Repl. Vol., 2015 Suppl.), § 15-501 of the Insurance Article ("INS") was inapplicable to this case. We shall address each of these arguments in turn.

Subtitle three of Title 27 of the insurance article of the Maryland Code prohibits insurers from engaging in unfair claim settlement practices, and affords claimants an administrative remedy for those who are aggrieved by an insurer's unfair claim settlement practice. INS § 27-301. Indeed, under Title 27 of the insurance article:

> It is an unfair claim settlement practice and a violation of this subtitle for an insurer, nonprofit health service plan, or health maintenance organization to:

> (1) misrepresent pertinent facts or policy provision that relate to the claim or coverage at issue;
>
> (2) refuse to pay a claim for an arbitrary or capricious reason based on all available information;
>
> (3) attempt to settle a claim based on an application that is altered without notice to, or the knowledge or consent of, the insured;
>
> (4) fail to include with each claim paid to an insured or beneficiary a statement of the coverage under which payment is being made;
>
> (5) fail to settle a claim promptly whenever liability is reasonable clear under one part of a policy, in order to influence settlement under other parts of the policy;
>
> (6) fail to provide promptly on request a reasonable explanation of the basis for a denial of a claim;
>
> (7) fail to meet the requirements of Title 15, Subtitle 10B of this article for preauthorization for a health care service;
>
> (8) fail to comply with the provision of Title 15, Subtitle 10A of this article;
>
> (9) fail to act in good faith, as defined under § 27-1001 of this title, in settling a first-party claim under a policy of property and casualty insurance; or
>
> (10) fail to comply with the provision of § 16-118 of this article.

INS § 27-303.

Kontosis contends that Hartford violated subsection INS § 27-303(2) by offsetting her disability benefit in an "arbitrary or capricious" fashion. In the context of unfair claim settlement practices, we have previously held that:

> [A] claimant must prove that the insurer acted based on "arbitrary and capricious reasons." The word "arbitrary" means a denial subject to individual judgment or discretion, WEBSTER'S II NEW RIVERSIDE UNIVERSITY DICTIONARY 121 (1984) and made without adequate determination of principle. BLACK'S LAW DICTIONARY 55 (Abridged 5th Ed.1983). The word "capricious" is used to describe a refusal to pay a claim based on an unpredictable whim. WEBSTER'S at 227. Thus, under [INS] § 27-303, an insurer may properly deny a claim if the insurer has an otherwise lawful principle or standard which it applies across the board to all claimants and pursuant to which the insurer has acted reasonably or rationally based on "all available information."

*Berkshire Life Ins. Co. v. Md. Ins. Admin.*, 142 Md. App. 628, 671 (2002).

Critically, the arbitrary or capricious standard is used to determine whether the *insurer* has engaged in an unfair claim settlement practice, and not whether the commissioner has processed the insured's claim in an arbitrary and capricious manner. Indeed, the relevant inquiry here is whether there is substantial evidence to support the commissioner's determination that the evidence did not show by a preponderance of the evidence that Hartford "refuse[d] to pay a claim for an arbitrary or capricious reason based on all available information." INS § 27-303(2).

### A. The MIA Did Not Err by Finding That Hartford Did Not Arbitrarily and Capriciously Apply Offsets to Kontosis's Policies.

Kontosis first contends that reducing her benefits under the group and association policy by considering SSDI benefit as other income, and considering her benefits under the group policy as other income under the association policy was arbitrary and capricious. Accordingly, Kontosis asserts that Hartford acted arbitrarily and capriciously when offsetting Kontosis's claims under the policy. The ALJ, in a proposed opinion largely adopted by the MIA, found that Hartford did not act arbitrarily and capriciously due to the express terms of the policy. We hold that there is substantial evidence to support the MIA's finding that the offsets applied by Hartford were neither arbitrary nor capricious.

The group policy provides that Hartford will calculate a claimant's monthly benefit as follows:

> 1) multiply [Your Pre-disability Earnings or Monthly Income Loss] by the Benefit Percentage;
>
> 2) compare the result with the Maximum Benefit; and
>
> **3) from the lesser amount, deduct Other Income Benefits.**

(emphasis added). Likewise, under the association policy the:

> Monthly Benefit for each month of Total Disability, not to exceed $4,000, will be calculated in the following manner:
>
> 1. Determine 66 2/3% of You Monthly Salary as of January 1st immediately preceding the date the Total Disability commences.

> 2. **Subtracting from the above amount the total amount of Other Income Benefits payable for the same monthly period (including any amount that is not received solely because of your failure to apply for such amount).**

(emphasis added).

Accordingly, each policy permits Hartford to subtract from Kontosis's monthly benefit any "Other Income Benefit." Under the association policy, "Other Income Benefits" includes a "plan or arrangement of coverage, whether insured or not, as a result of employment by or association, union or other organization." The association plan, therefore, expressly classifies benefits received under the group policy as "Other Income Benefits." Moreover, both the association policy and the group policy require the claimant to apply for SSDI benefits, and classify any disability benefits received from social security as "Other Income Benefits."

In order to violate INS § 27-303(2), the MIA must find that Hartford refused to pay a claim "for an arbitrary or capricious reason." Where, as here, Hartford's application of the offset provision was guided by the clear and unambiguous language of Kontosis's insurance policies -- which expressly permit just this type of offset -- we hold that there was substantial evidence to support the MIA's finding that Hartford did not act on an unpredictable whim or did not give adequate consideration to Kontosis's contention. *Berkshire Life Ins. Co.*, *supra*, 142 Md. App. at 671. We, therefore, affirm the MIA's finding that Hartford did not act arbitrarily or capriciously by applying the offsets to Kontosis's benefits.

### B. The MIA Did Not Err by Finding That Hartford Did Not Engage In An Unfair Claims Settlement Practice By Seeking Reimbursement for An Overpayment.

Kontosis further alleges that Hartford engaged in an unfair claims settlement practice by "seeking reimbursement of $18,578.16 under the association policy as an offset to her retroactive receipt of previously terminated benefits under the [group] policy." Kontosis cites no authority in support of her argument that she is entitled to retain the amount she was overpaid. *See Anderson v. Litzenberg*, 115 Md. App. 549, 578 (1997) ("[B]ecause appellants, in their brief, cited no authority for their position, their contention was deemed waived. . . . It is not our function to seek out the law in support of a party's appellate contentions."). Instead, Kontosis declares that because -- in her opinion -- she is "between the poor administrations of two policies" she is entitled to a windfall in the amount of $18,578.16 that she would not have otherwise been entitled to under the terms of her policies.

We note that Hartford contends that it sought reimbursement pursuant to the terms of the association policy. Upon our review of the administrative record, we observe that the group policy contains specific and express terms governing how Hartford intends to remedy an overpayment should one arise. The association policy, on the other hand, contains no such provision governing an overpayment made under a policy. The question as to whether Hartford was legally entitled to offset the amount of an overpayment against Kontosis's benefits under the association policy, however, is not before us on this appeal.

Rather, the relevant question here is merely whether there was substantial evidence to support the MIA's conclusion that Hartford did not act arbitrarily or capriciously in offsetting Kontosis's benefits in order to recover an outstanding debt.

In his comprehensive opinion, the ALJ determined that "common sense suggests that if the policyholder has an outstanding debt to the Licensee, the Licensee is entitled to suspend payments under the policy until reimbursement occurs." Other than condemning Hartford's management of her policies as "poor[ly] administ[ered],"[5] Kontosis cites us to no authority entitling her to a windfall of $18,578.16, or prohibiting Hartford from withholding payments to Kontosis until Kontosis satisfies her debt to Hartford. Accordingly, we hold that there is substantial evidence to support the MIA's determination that Hartford did not act arbitrarily or capriciously by demanding reimbursement of an overpayment made under the association policy.

### C. The MIA Did Not Err by Failing To Apply INS § 15-501 to Title 27 of the Insurance Article.

[5] We do not mean to imply that we agree with Kontosis's contention that her policies were "poor[ly] administ[ered]." To the contrary, the impetus of Kontosis's overpayment was a post hoc consequence of an adjudication involving a completely different policy. Moreover, the genesis of Kontosis's deficiency under the group policy -- the resolution of which caused an overpayment under the association policy -- was actually caused by Kontosis when she failed to receive an updated medical evaluation verifying her continued disability as required under that policy. In any event, assuming *arguendo* the legitimacy of Kontosis's characterizations as to the administration of her policies, such a characterization is immaterial to our opinion on this issue.

Critically, the arbitrary or capricious standard applied in INS § 27-301 (2) is employed to determine whether the *insurer* has engaged in an unfair claim settlement practice, and not whether the commissioner has processed the insured's administrative claim for relief in an arbitrary and capricious manner. Indeed, the relevant inquiry here is whether there is substantial evidence to support the commissioner's determination that the evidence did not show by a preponderance of the evidence that Hartford "refuse[d] to pay a claim for an arbitrary or capricious reason based on all available information." INS § 27-303(2).

Notably, the interplay between subtitle three of Title 27 of the insurance article, Title 15 of the insurance article, and the common law of contracts creates a construct under which there are multiple avenues to resolve insurance disputes. Indeed, "[t]he intent of [subtitle three of article 27] is to provide an additional administrative remedy to a claimant for a violation of this subtitle or a regulation that relates to this subtitle." INS § 27-301(a). Yet, "[t]he Maryland Unfair Claim Settlement Practices Act specifically states that it does not create a private right of action." *Conn. Gen. Life Ins. Co. v. Ins. Comm'r for the State of Md.*, 371 Md. 455, 472 n.7 (2002) (citing INS § 27-301(b)(2)("This subtitle does not provide or prohibit a private right or cause of action to, or on behalf of, a claimant or other person in any state.")). Moreover, "[t]his subtitle does not impair the right of a person to seek redress in law or equity for conduct that otherwise is actionable." INS § 27-301(b)(3). Alternatively, subtitle 10A of Title 15 of the insurance article sets

forth an administrative procedure for an insured to challenge an adverse decision or a grievance decision made by an insurer. INS §§ 15-10A-01–15-10A-05.

Each of the three remedies available to address insurance disputes often overlap in the scope of conduct they regulate. Yet on the other hand, each particular remedy has a distinguishable end that it aims to further. To illustrate, if an insurer acts contrary to its obligations under an insurance contract, a common law action for breach of contract may be available. *See generally*, *Carter v. Huntington Title & Escrow, LLC*, 420 Md. 605 (2011) (holding that the MIA has primary jurisdiction over claims for violations of the insurance article, but that courts have concurrent jurisdiction over common law claims). The common law remedy resulting from a breach of contract action, however, only seeks to provide redress to a non-breaching party while otherwise promoting the efficient breach of contract. *See* Oliver Wendell Holmes, *The Path of the Law*, 10 Harv. L. Rev. 457, 462 (1897) ("The duty to keep a contract at common law means a prediction that you must pay damages if you do not keep it, – and nothing else.").

Likewise, a claimant may pursue administrative remedies for violations of the insurance article under the provisions of Title 15 of that article. Under Title 15 of the insurance article, a breach of an insurance contract may always be redressed through the administrative process outlined in INS § 15-10A-03. INS § 15-10A-04(c)(1)("It is a violation of this subtitle for a carrier to fail to fulfill the carrier's obligations to provide or reimburse for health care services specified in the carrier's policies or contracts with

members."). The scope of conduct violative of Title 15 of the insurance article necessarily includes a breach of an insurance contract that would be actionable as a common law breach of contract. Moreover, the commissioner's review of a grievance decision under subtitle 10A of Title 15 is broader in scope than a common law contract action because it encompasses not only a review of the parties' rights under the contract, but also a determination as to whether the insurer is in compliance with the statutory provisions of the insurance article. INS § 15-10A-03 (e)(1) ("A carrier shall have the burden of persuasion that its adverse decision or grievance decision, as applicable, **is correct**." (emphasis added)).

Accordingly, by enacting the Insurance Article, the General Assembly supplements the common law to the extent that it not only provides redress for the breach of a promise in an insurance contract, but also gives consumers administrative remedies when an insurer acts contrary to the public policy expressed by the legislature in that article. *See e.g.*, *Carter*, *supra*, 420 Md. at 622 ("In enacting the Insurance Article, the Legislature accorded aggrieved consumers . . . an administrative remedy for being charged excessive insurance premiums.").

In recognition of the fact that the insurance article was enacted by the legislature to further a public policy beyond that of mere breach of contract action, Title 15 of the insurance article provides for the recovery of damages in excess of those available in a mere breach of contract action. Indeed, under INS § 15-10A-04, if the commissioner

determines that an insurer wrongfully rendered an adverse decision or made a wrongful grievance decision, the commissioner may:

> (I) issue an administrative order that requires the carrier to:
>
> > 1. cease inappropriate conduct or practices by the carrier or any of the personnel employed or associated with the carrier;
> >
> > 2. fulfill the carrier's contractual obligations;
> >
> > 3. provide a health care service or payment that has been denied improperly; or
> >
> > 4. take appropriate steps to restore the carrier's ability to provide a health care service or payment that is provided under a contract; or
>
> (ii) impose any penalty or fine or take any action as authorized . . .

INS § 15-10A-04(c)(2).

Critically, while subtitle 10A of Title 15 provides for potential remedies in excess of those otherwise available in a contract action, this authority does not specifically give the commissioner authority to punish conduct by insurers that is not consistent with the policy expressed by the legislature in that Title. Rather, only by incorporating other provisions of the insurance article, may the commissioner levy fines, penalties, or other punitive sanctions against an insurer. INS § 15-10A-04(c)(2)(ii)(1). Accordingly, the primary purpose of Title 15 is only to give redress to an aggrieved consumer for conduct by an insured that is not in accordance with the policy directives of the General Assembly.

In addition to common law and administrative remedies under Title 15 of the insurance article, if the insurer's conduct rises to the level of an unfair claim settlement practice, a claimant may petition the commissioner of the MIA to utilize the punitive sanctions outlined in INS § 27-305. Subtitle three of Title 27 exists to deter insurers from engaging in unfair claim settlement practices. In furtherance of this objective, INS § 27-305 makes available to the administrative agency a panoply of enforcement mechanisms to ensure compliance with this subsection. For example, in addition to paying restitution to the victim, the commissioner may impose punitive monetary penalties and award attorney's fees if an insurer engages in an unfair claim settlement practices. INS § 27-305(a),(c)(3).

The critical distinction between Titles 15 and 27 of the insurance article is that Title 15 exists primarily to provide redress to consumers, whereas Title 27 exists to punish conduct that the insurer either knows or should know is an unfair claim settlement practice. This distinction is evinced by the fact that the mandate articulated in INS § 15-10A-04(c) prohibits the ends of "fail[ing] to fulfill the carrier's obligations . . ." whereas the mandate in INS § 27-303 prohibits the exact same ends **only** through one of ten specifically enumerated means. Indeed, Title 15 imposes strict liability on an insurer whose practices fail to comport with that Title, but each of the ten prohibitions punishable under INS § 27-303 require the insurer to have engaged in some sort of specific conduct that the legislature has deemed to be particularly culpable. To illustrate, Hartford's refusal to pay a claim

might entitle Kontosis to a remedy under Title 15 if "the carrier . . . fail[ed] to fulfill the carrier's obligations . . ." INS § 15-10A-04. The remedy under Title 15, therefore, is intended to compensate the claimant for the insurer's failure to satisfy its obligation **even if** the insurer had a subjective belief that they were justified in refusing to pay a claim. The insurer is only exposed to the punitive sanctions of INS § 27-305 for violating INS § 27-303(2) if the insurer fails to fulfill its obligations while acting "arbitrar[ily] or capricious[ly]." INS § 27-303(2).

This distinction is further buttressed by the fact that under INS § 27-303(8), it is an unfair claims settlement practice to "fail to comply with the provision of Title 15, Subtitle 10A of this article." Notably, an insurer's violation of Title 15 of the insurance article, while actionable under subtitle 10A of that title, is not an unfair claims settlement practice *per se*. Rather, only after an insurer refuses to comply with the provisions of subtitle 10A of Title 15, does a violation of Title 15 rise to the level of an unfair claims settlement practice. To hold otherwise would render all ten of the specifically enumerated *actus rei* articulated in INS § 27-303 superfluous. Indeed, Kontosis's reading of INS § 27-303 would make any breach of an insurance contract -- no matter how immaterial or benign -- tantamount to an unfair claim settlement practice. If such was the General Assembly's intent, it would not have divided the remedial and punitive sanctions relevant to insurance coverage disputes among two separate titles in the insurance article. Accordingly, pursuant to the clear and unambiguous text of INS § 27-303, only the particular *actus rei*

articulated therein may constitute an unfair claim settlement practice. A breach of an insurance contract or other violation of Title 15 of the insurance article only constitute unfair claims settlement practices when they fit within one of the ten specifically enumerated criteria articulated in that authority.

In this action, Kontosis claims that Hartford engaged in an unfair claims settlement practice by violating INS § 15-501. Section 15-501 of the insurance article provides:

> An individual, group, or blanket health insurance contract may not contain a provision that reduces payment to an individual entitled to receive disability payments under the contract because the individual receives an increase in Social Security payments.

INS § 15-501.

The ALJ determined that Hartford had not violated INS § 15-501 because "a disability insurance policy is not a type of health insurance,"[6] and that this provision only applies when a reduction in benefits is applied because a claimant's social security benefits

[6] Kontosis observes that the ALJ erred when he determined in his proposed decision that "[t]he Group and Association Policies are not health insurance contracts." Indeed, Kontosis is correct that the policies at issue here are health insurance contract. *See* INS § 1-101(p) (including disability insurance within the scope of health insurance). The ALJ's erroneous statement, however, was not incorporated into the final administrative decision, because upon being presented with the ALJ's proposed decision, the deputy commissioner of the MIA noted that the failure to consider the policies at issue to be health insurance policies was an error. Accordingly, although the MIA ultimately adopted the ALJ's conclusions, the final administrative decision corrected the ALJ's immaterial error when the deputy commissioner observed that "a disability insurance policy is a type of health insurance policy."

are increased. In this appeal, however, we need not endorse the MIA's or the ALJ's interpretation of INS § 15-501, because in this instance the failure to comply with INS § 15-501 does not necessarily constitute an unfair claims settlement practice.

It is critical for our analysis that the procedural posture of this case is such that Kontosis has only alleged an unfair claim settlement practice. Had Kontosis made a claim to the MIA under Title 15, subtitle 10A of the insurance article, the MIA would have had the opportunity to opine on the construction of INS § 15-501. Then, in an appeal from the MIA's Title 15, subtitle 10A decision, we would address the legal question as to the construction of INS § 15-501 *de novo* while giving appropriate deference the agency's interpretation of a statute which it administers. *Hranicka v. Chesapeake Surgical, Ltd.*, 443 Md. 289, 297-98 (2015) ("a great deal of deference is owed to an administrative agency's interpretation of its own regulation." (internal quotations omitted)). Following that decision, the insurer's failure to comply with the MIA's directive would constitute an unfair claim settlement practice under INS § 27-303(8).

In this case, it was unclear as to under what authority Kontosis was seeking relief as she was representing herself *pro se* before the MIA. Indeed, before the ALJ, however, the ALJ articulated that it was his understanding that "[t]his hearing involves an allegation of an unfair claim settlement practice. That would be under section 27-303." Shortly thereafter, Kontosis cited the ALJ to INS § 15-1010 which appears in a subtitle requiring insurers to create an internal review procedure for the review of claims decisions. The ALJ's opinion, however, indicates that it was the prevailing understanding that INS

§ 27-303 was the sole basis upon which Kontosis sought relief. Indeed, the ALJ noted that "[o]n October 1, 2013, the [MIA] received a complaint from [Kontosis] alleging unfair claims settlement practices by [Hartford]." Accordingly, the MIA made no determination as to whether Hartford violated Title 15, as its inquiry was limited to whether Hartford had engaged in an unfair claims settlement practice. As such, we cannot exercise original jurisdiction and decide whether Hartford's conduct was violative of INS § 15-501 so as to entitle Kontosis to relief under INS § 15-10A-04 in the first instance.

Additionally, had there been a strong body of authority adopting Kontosis's construction of INS § 15-501 such that Hartford's failure to abide by that interpretation amounts to a decision made "without adequate determination of principle," then Hartford might be said to have arguably acted arbitrarily or capriciously. *Berkshire Life Ins. Co.*, *supra*, 142 Md. App. at 671. Our research -- thorough we trust -- however, has not unearthed any authority construing INS § 15-501. Moreover, we are unwilling in this appeal to both construe for the first time the statutory provision of INS § 15-501, and then condemn Hartford's construction of that statute as arbitrary or capricious if it does not comport with our interpretation. Rather, our review is limited to a determination as to whether the MIA's determination that Hartford did not act arbitrarily or capriciously "based on all available information" is supported by substantial evidence. INS § 27-303(2).

In this case, we cannot say that Hartford's construction of INS § 15-501 (which was also adopted by the ALJ) was made on an unpredictable whim or did not give adequate consideration to Kontosis's contention. *Berkshire Life Ins. Co.*, *supra*, 142 Md. App. at

671. Indeed, Kontosis petitioned the ALJ to determine that Hartford's offset was an unfair claim settlement practice in violation of INS § 15-501, without first determining whether Hartford actually violated INS § 15-501. Here, we only hold that the MIA did not err in finding that Hartford's construction of INS § 15-501, was not arbitrary and capricious so as to constitute an unfair claim settlement practice under the subjective standard articulated in INS § 27-303.

## III. Conclusion

For the reasons stated in Part II (A), *supra*, the MIA did not err in finding Hartford's enforcement of Kontosis's insurance policy did not constitute an unfair claim settlement practice. Moreover, the MIA did not err in finding Hartford's offset to recover an overpayment not to constitute an unfair claim settlement practice. Finally, the MIA did not err in finding that Hartford's construction and appellation of INS § 15-501 was not an unfair claim settlement practice. We, therefore, affirm the judgments of the MIA and the Circuit Court for Prince George's County.

**JUDGMENT OF THE CIRCUIT COURT FOR PRINCE GEORGE'S COUNTY AFFIRMED. APPELLANT TO PAY COSTS.**